HISTORICAL MILESTONES OF
THE MANAGED RISK MEDICAL INSURANCE BOARD

Authored By: Dennis Gilliam

May 25, 2006

1989:

The Legislature passed and Governor George Deukmejian signed into law Chapter 1168, Statutes of 1989, which established the Major Risk Medical Insurance Board (MRMIB). The Board was originally housed in the Business, Transportation and Housing Agency. The Statute tasked the Board with two main objectives:

The Legislature passed and Governor George Deukmejian signed into law Chapter 1168, Statutes of 1989, which established the Major Risk Medical Insurance Board (MRMIB).

To establish and manage the Major Risk Medical Insurance Program (MRMIP), a high risk insurance pool to "secure adequate health coverage" for Californians with preexisting conditions who did not have employer or other private or public program based coverage, and who were being excluded from the individual and small group insurance market because of their preexisting conditions.

"To research and assess the needs of persons not adequately covered by existing private and public health care delivery systems and promote means of assuring the availability of adequate health care services."

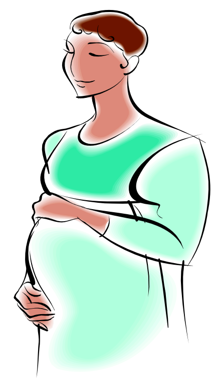
1990:

Governor Deukmejian and the Legislature made the first appointments to the five person volunteer board. Under the law, the Governor appoints the chair and two other persons, and the Senate Committee on Rules and Speaker of the Assembly each appoint a person. All serve four year terms. Clifford Allenby, then Secretary of Health and Welfare, was appointed the first Chair. The rest of the original Board members were: Governor appointees Ronald Kaldor and Ralph Schaffarzick M.D.; Assembly appointee B. Emery "Soap" Dowel; and Senate appointee Rita Gordon. In addition, the Secretary of Business, Transportation and Housing served on the Board as a non-voting, Ex-Officio member.

The Board selected John Ramey, then Deputy Secretary of Health and Welfare, as the first Executive Director. The original staff totaled seven civil servants and an intern and shared a tiny two room office, loaned by the Department of Health Services (DHS), at 744 P Street. The Executive Director's "space" also doubled as the photocopy room. The Board entered into an arrangement with Office of Statewide Health Planning and Development (OSHPD) to provide administrative support services, such as personnel, accounting, budgets and business services.

1991:

MRMIP became operational in late January with 400 original subscribers and an enrollment target of 10,000 persons. California was the 14th state to establish a health insurance high risk pool. By the end of the year the program was at capacity, with a waiting list of nearly 3,500 persons



Blue Cross of California was selected to be the "Administrative Vendor" for MRMIP, handling the details of eligibility determination and enrollment. Blue Cross and five other plans provided insurance coverage through contracts with the Board. The Board contracted with Coopers and Lybrand (now PricewaterhouseCoopers) as its consulting actuary.

AIM provided full health coverage to the mother to be, and two years of full health coverage for the AIM born baby.

The Legislature passed and Governor Pete Wilson signed into law Chapter 278, Statutes of 1991 (AB 99), which established the Access for Infants and Mothers (AIM) Program under Board management. AIM is part of a broader government strategy to provide California with a more comprehensive approach to providing perinatal care and improving the State's birth outcomes. As originally enacted, AIM targeted low and moderate income women with income above 200% through 250% of the Federal Poverty Level and pregnant women with family income under 200% FPL who had assets that made them ineligible for the Medi-Cal Program. AIM uses a non-entitlement, insurance based model, with family premium contributions. It provides full health coverage to the mother to be, and, as originally enacted, also provided two years of full health coverage for the AIM born baby. J.P. Kennedy Company Insurance Services was selected as the original administrative vendor for the program.

Statue was enacted which moved the Board from the Business, Transportation and Housing Agency to the Health and Welfare Agency. Both agencies retained non-voting Ex-Officio membership on the Board, and another Ex-Officio member was named, the Chair Person of the AIM Advisory Panel established under the AIM statute.

1992:

AIM became operational in January. By the end of the year the Board had a network of ten plan contractors, allowing for statewide services. Board staff increased to ten persons. Slow initial enrollment in AIM prompted the Board to establish a network of three regional outreach contractors to educate local stakeholders about the new program.

The Board moved out of its loaned space to new larger space shared with OSHPD at 818 K Street.

With only $30 million a year in Cigarette and Tobacco Surtax funds for State subsidy, the MRMIP waiting list grew to 4,200 with delayed entry into the program of nearly a year. The first actuarial analysis of the program costs found the average cost per person to be lower than originally projected and the enrollment cap was raised to 14,100.

Under the motto "a program a year is all we ask," the Board actively worked with the Legislature, the Wilson Administration and the Department of Insurance to pass Chapter 1128, Statutes of 1992 (AB 1672). This Act resulted in significant reforms to the small group insurance market that stabilized access and pricing within that market. These reforms effected coverage sold to small employers, originally defined as employers with 3 to 50 employees and (later defined as ones with 2 to 50 employees.

HIPC was a statewide purchasing pool for small employers that provided to them the kind of choice that large companies offer.

The Act also established a new program under Board management, which became known as the Health Insurance Plan of California (HIPC). The HIPC was a statewide purchasing pool for small employers that provided to them the kind of choice that large companies offer. The challenge and goal of the HIPC was to create a pool that increased access for small employers, provided coverage at lower costs and was self supporting. The Board selected Employers Health Insurance of Green Bay, Wisconsin as the administrative vendor for the HIPC.

1993:

The HIPC Program began in July with a contract network of 19 health plans, allowing for statewide coverage. By year end, 1,909 small groups and 32,587 employees and dependents were enrolled.

In recognition of the Board's expanding role, the Legislature, in Chapter 1146, Statutes of 1993, changed the name of the Board to the Managed Risk Medical Insurance Board. MRMIB staff expanded to 14 persons to manage the HIPC and its other two programs.

AIM enrolled 11,019 new mothers in 1993. In July, a new administrative vendor, Health Care Alternatives, a subsidiary of Maxicare Health Plan took over.

1994:

Thomas Topuzes and S. Kimberly Belshé were appointed to the Board by Governor Wilson.

MRMIP remained in an expansion mode, with an enrollment target of 18,040 set in the spring. Blue Cross established a MRMIP look-alike program to serve applicants on the waiting list, giving them the option to purchase coverage at unsubsidized rates until they could enter MRMIP.

AIM continued to expand to the point that its capped appropriation was running low. AIM was closed to new enrollment in February in order to serve its continuing members and outreach was suspended. The Legislature provided more funding for AIM in the 1994-1995 Budget and eliminated the asset test for Medi-Cal's program for pregnant women. After a health plan re-procurement, AIM re-started in August with a floor of 200% of the federal poverty level.

MRMIP remained in an expansion mode, with an enrollment target of 18,040 set in the spring.

AIM continued to expand to the point that its capped appropriation was running low.

The Board established the HIPC Dental Program through regulations and selected seven dental plan contractors. By year end, the HIPC enrolled 4,278 small groups and 79,898 employees and dependents.

1995:

Due to the 1994 closure of AIM and its newly created income floor, the Board struggled to bring AIM back to full capacity. The three region outreach network was re-established and the Board raised the AIM income ceiling to 300% of the federal poverty level.

The Board was awarded a grant from the prestigious Robert Wood Johnson Foundation to establish a pioneering Risk Assessment/Risk Adjustment (RA/RA) Project for the HIPC. The Project was designed by Board staff and its actuarial consultants at Coopers and Lybrand and implemented through the cooperation of HIPC plans. Under RA/RA, plans that attract greater risk were subsidized by plans with the lowest risk mix. The goal of risk assessment was to protect plan choice by accounting for the higher risk drawn by certain plans such as Preferred Provider Organizations in the HIPC.

The Board was awarded a grant from the prestigious Robert Wood Johnson Foundation to establish a pioneering Risk Assessment/Risk Adjustment (RA/RA) Project for the HIPC.

By the end of 1995, the HIPC had broken the 100,000 member barrier and was the largest public small group pool in the nation.

1996:

The Board appointed Sandra Shewry as its second Executive Director.

The Board successfully sponsored legislation to make the MRMIP subscriber premiums more reflective of rising program costs, while maintaining plan choice. Under the resulting law, Chapter 792, Statutes of 1996 (SB 661), subscribers who select plans with higher than average loss ratios, (which therefore required a larger state subsidy), pay up to 10% higher than the statutory premium in MRMIP (125% of normal market rates). This temporarily helped MRMIP to increase enrollment. The Program served 22,915 clients in 1996.

Staff of the Board and its consulting actuary published an article on the HIPC's Risk Assessment/Risk Adjustment in the spring, 1996 issue of the prestigious journal, Health Affairs.

The enabling legislation for the HIPC Program required the Board to give administrative and financial control of the program to nonprofit entities after three years of State management, through a competitive process. The Board issued an RFP for HIPC privatization, calling for one state-wide nonprofit entity to take over the HIPC. No agency responded to the RFP. The HIPC Program plan contracts were re-procured. By the end of 1996, the HIPC had 6,500 small groups and 120,999 enrolled employees and dependents.

The AIM Program saw modest growth and served 4,309 new mothers. AIM was a factor in reducing the number of uninsured births in California from 4.48% in 1991, the year before AIM started, to 2.86% in 1996.

Congress added Title XXI to the Social Security Act, the largest expansion of federally sponsored health care coverage since the enactment of Medicare and Medicaid in 1964.

~~~~~~~~~~~~

Legislation was passed in August (Chapter 623, Statutes of 1997; AB 1126) establishing the Healthy Families Program (HFP) under the Board.

1997:

Congress added Title XXI to the Social Security Act, the largest expansion of federally sponsored health care coverage since the enactment of Medicare and Medicaid in 1964. Title XXI established the State Children's Health Insurance Program (SCHIP), which made large grants to the states to cover children in working families with incomes too high to be served through state Medicaid programs. Title XXI gave States the option of expanding Medicaid, establishing a new stand-alone program, or a combination of the two. California opted for the combination approach, with the bulk of federal funding going to a new program under management of the Board. Legislation was passed in August (Chapter 623, Statutes of 1997; AB 1126) establishing the Healthy Families Program (HFP) under the Board. Under the model established in the Act, the Department of Health Services (DHS) also had key role, providing a joint outreach and application assistance program for Children's Medi-Cal and HFP, providing the services of an expanded California Children's Services Program to HFP children with severe or chronic health conditions, and using SCHIP funding to expand Children's Medi-Cal. Also under the model, county mental
~~~~~~~~~~~~

health departments provided services to severely emotionally disturbed children enrolled in the HFP, under the direction of the Department of Mental Health.

The State enabling legislation established a Healthy Families Advisory Panel, made up of representatives of key stakeholders in children's health. The Chairperson of that panel was added to the Board as a non-voting Ex-Officio member.

In November, the Governor submitted the Title XXI State Child Health Plan to the U.S. Department of Health and Human Services. The State Plan was jointly prepared by DHS and the Board staff. The plan provided for HFP coverage to families with incomes higher than 100% and up to 200% of the Federal Poverty Level (depending on the age of the children). The Board began the process of tripling its staff to implement and manage the new program.

The Board issued another RFP to privatize the HIPC Program. In response to a protest, the Department of General Services rejected the Board's choice of bidder.

The Legislature appropriated another $10 million from Tobacco Surtax Fund to MRMIP to maintain enrollment levels, the first such increase in the history of the program.

By December, the HIPC, still under Board control, had 7,174 small groups and 133,622 employees and dependents.

AIM enrollment dropped to 3,452 newly enrolled mothers and the Board tried new outreach strategies through its outreach contract network, including greater collaboration with hospitals and radio and television public service announcements in English and Spanish.

The Legislature appropriated another $10 million from Tobacco Surtax Fund to MRMIP to maintain enrollment levels, the first such increase in the history of the program. MRMIP served 25,253 subscribers during the year. Blue Shield joined Blue Cross in adding a look-alike product for persons on the waiting list.

<u>1998:</u>

Sandra Hernandez, M.D., was appointed by the Senate to the Board.

Work continued to implement the Healthy Families Program. Early in the year, there was a controversy over the selection of an administrative vendor for the HFP. It revolved around whether a health plan that participates as a health plan in the HFP should also serve as administrative vendor, as had been the case in both the Major Risk and HIPC programs. The Board's decision on the administrative vendor selection was delayed by the controversy. In March, the Board selected Electronic Data Systems Corporation (EDS) to administer the program. The Board initially selected thirty health plans, four dental plans and one vision plan to provide HFP services to children. The plans were a mix of statewide and regional commercial plans as well as the Local Initiatives and County Organized Health Systems that had been serving as Medi-Cal managed care contractors. Three of the proposed health plan contractors dropped out prior to the HFP implementation date. The new program began in July and 5,259 children enrolled that first month. By the end of the year, the program had enrolled 56,237 children age one through eighteen.

The Board headquarters at 818 K Street were very cramped as staff strength ramped up from 14 persons to nearly 50 to implement the new program.

The Board headquarters at 818 K Street were very cramped as staff strength ramped up from 14 persons to nearly 50 to implement the new program. OSHPD and DHS provided additional space but in April Board staff was consolidated at the Board's new and current headquarters at 1000 G Street.

The Board tried to privatize the HIPC Program for the third time. Three proposals were received and the Board's selected the Pacific Business Group on Health (PBGH). The selection resulted in a formal challenge. This time the Department of General Services upheld the Board's selection. PBGH is a non-profit entity that provides assistance to some of the state's largest corporations and institutions in purchasing health coverage and improving the quality of employee health care. The Board entered into a ten month transition contract with PBGH, which allowed PBGH to take over day to day management of the HIPC and set certain goals which PBGH had to meet in order to take over the program completely. By December, the HIPC enrolled 7,878 small groups and 147,063 employees and dependents.

The MRMIP reached the high point of its enrollment, serving 27,160 persons. After that, enrollment steadily eroded, since the growing cost of providing health care reduced the number of people who could be served by the unchanging $40 million appropriation for the Program.

A survey of AIM participating mothers taken for the 1998 AIM Fact Book (published in January 1999), indicated that 98% of women were satisfied or very satisfied with the Program. Furthermore, the Fact Book published several strong indicators of AIM Program quality. Forty-four percent of women entered AIM during the first trimester and 93% had eight or more prenatal visits. Only 4.3% of AIM babies had low birth weights, besting a national goal for the year 2000, of keeping low birth weights under 5%. Ninety-three percent of AIM babies received their first year vaccinations, compared to 74% of California children in general. The Board fully implemented a new strategy for its network of AIM outreach contractors. The regional contractors supported the administrative vendor by providing intensive assistance for families with incomplete applications. As a result, AIM enrollment was growing again, with an enrollment of 4,286 new mothers.

1999:

During 1999, the Board was temporarily chaired by a representative from new Governor Gray Davis' Office. The temporary Chair was Tal Finney.

HFP was now up and running, but was not achieving the enrollment levels the Board and the Governor desired. MRMIB and DHS completed a project to make the joint HFP/Medi-Cal for Children application shorter and clearer. The application booklet shrank from 29 pages to 10 and the application itself was cut from 16 pages to 4.

Under SPE, a special unit at EDS would screen the joint application for both HFP and Medi-Cal eligibility.

In April, the Board and DHS started the Single Point of Entry (SPE) at EDS. Under SPE, a special unit at EDS would screen the joint application for both HFP and Medi-Cal eligibility. Those potentially eligible for Medi-Cal would be forwarded to the appropriate county welfare department for further action and those potentially eligible for HFP would be acted upon by EDS.

The new administration of Governor Gray Davis supported raising the level of income disregard, which would raise the HFP income ceiling from 200% to 250% of the Federal Poverty Level. The effective change was included in the

1999-2000 State Budget. The program was also expanded to enroll infants through age one in families with incomes above 200%, and infants in families below that would remain in Medi-Cal. By the end of the year, HFP enrollment exceeded 200,000 children.

The Board made the first awards to five of the participating plans in HFP for Rural Health Demonstration Project. Funded projects included rate enhancements to improve provider choice for HFP enrollees in rural areas, special population rates to cover the children of migrant workers in several occupations as the families moved around the State and grants to provide better access and higher quality services for all targeted children in rural areas.

The Board made the first awards to five of the participating plans in HFP for Rural Health Demonstration Project.

PBGH successfully completed the transition contract for the HIPC and took over management from the Board in July. PBGH renamed the program, PacAdvantage. At that point, the HIPC covered 8,216 small groups and 144,424 employees and dependents.

AIM enrolled 5,035 new mothers in 1999.

The maximum benefit and lifetime caps for MRMIP were increased. The annual cap increased from $50,000 to $75,000 and the lifetime cap increased from $500,000 to $750,000. The maximum enrollment level was reduced to 21,124, in small part because of the benefit cap increase, but largely because of medical inflation and the fixed appropriation for MRMIP. The California Health Care Foundation gave the Board a two million dollar grant to maintain enrollment. The Board published the 1999 MRMIP Fact Book, which included a 1998 survey of subscribers. Eighty-four percent indicated that they were satisfied with the program and 89% were satisfied with their health plans.

2000:

In January, Governor Gray Davis appointed John L. Geesman as Chair of the Board.

Governor Davis signed Chapter 946, Statutes of 2000 (AB 1015), which directed the Board to add coverage for parents of children enrolled in HFP in families with incomes up to and including 200% of the Federal Poverty Level. This was to be enacted within four months of getting federal approval for the Parental Expansion. However, getting that approval would be a challenge.

The Board initiated a program satisfaction survey for HFP, using the nationally recognized survey model, the Consumer Assessment of Health Plan Survey or CAHPS™, through a contract with DataStat, Inc. The first survey was completed in December 2000 and published in 2001.

The Board initiated a program satisfaction survey for HFP, using the nationally recognized survey model, the Consumer Assessment of Health Plan Survey.

The Board re-procured health, dental and vision plan contracts for the HFP. All but one of the original contractors renewed and the Board added a new health and a new vision plan.

By the end of year 362,373 children were enrolled in HFP.

AIM enrolled 5,408 new mothers.

The Blue Cross and Blue Shield look-alike products for the MRMIP Waiting List were not renewed. All persons in the look-alike products were phased out by 2002. Maximum enrollment target levels were reduced to 18,322.

2001:

Clifford Allenby was re-appointed to the Board by Governor Davis, after a three plus year hiatus. DHS Director Diana M. Bonta also was appointed by the Governor to the Board. Areta Crowell, Ph.D. was appointed to the Board by the Assembly.

The Board began collaboration with the Center for Child Health Outcomes at the Children’s Hospital and Health Center of San Diego to evaluate the impact of HFP coverage on the health status of member children. The pioneering study, called the Health Status Assessment Project, was funded by the David and Lucille Packard Foundation. The Center established the baseline for the study in 2001.

The Board and RAND Corporation, in conjunction with the Dental Quality Improvement Work Group, developed the nation’s first CAHPS™ survey for dental plans, which was deployed by DataStat, Inc. for all dental plans in the HFP in 2002.

By year end, HFP had an enrollment of 506,635 children.

Governor Davis signed Chapter 648, Statutes of 2001 (AB 495). This law established a fund through which county insurance programs for children could seek Title XXI SCHIP funding for federally eligible children with incomes between 250-300% FPL by providing county funds in lieu of the State's contribution. The program was later referred to as the County Children's Health Insurance Program, or C-CHIP.

The Board revamped AIM eligibility standards to better align AIM with Medi-Cal and the HFP.

AIM enrolled 5,965 new mothers.

The California Health Care Foundation grant to maintain MRMIP enrollment levels was renewed. Even with the additional funding stream, the Board had to set a lower enrollment target and the waiting list reached an historic high of 7,098 by November.

2002:

The Centers for Medicare and Medicaid Services (CMS) approved the Parental Expansion Waiver as a five year demonstration project in late January. The Board, EDS, and plan contractor staff continued to work hard to implement the expansion by July 2002. However, the State's worsening budget situation forced the Administration to delay the start of Parental Expansion to better times. The five year CMS project approval period will be over in early 2007.

However, the State's worsening budget situation forced the Administration to delay the start of Parental Expansion to better times.

The first year results form the HFP Health Status Improvement Project, using the PedsQL™ survey instrument, indicated a marked improvement in the physical and psychosocial health status for children in poor health when they entered HFP and showed significant improvement, in accessing and using health care resources for the HFP population as a whole. The survey also indicated a significant improvement in both school attendance and performance for HFP children entering the program in poor health.

By the end of 2002, HFP enrollment was at 621,291 children.

In March 2002, Care 1st Health Plan took over as administrative vendor for the AIM Program, as part of its takeover of Maxicare's Heath Care Alternatives subsidiary.

AIM enrolled 7,411 new mothers.

AB 1401 set up a four year Guaranteed Issue Pilot Program under which enrollment in MRMIP was limited to no more than thirty six consecutive months.

The enrollment level targets for MRMIP were reduced to 14,658. In rejecting a higher level of state funding for MRMIP, Governor Gray Davis challenged the Board and the health insurance industry to develop a market based solution for high risk individuals that improved access for high risk populations but does not increase the level of government spending. In response to this challenge, a bill, AB 1401, was passed and signed by the Governor as Chapter 794, Statutes of 2002. AB 1401 set up a four year Guaranteed Issue Pilot Program under which enrollment in MRMIP was limited to no more than thirty six consecutive months. After that, risk pool members lose their MRMIP eligibility and all health plans and insurers in the individual market must offer them an equivalent benefit package on a guaranteed issue basis, priced at 10% above the MRMIP premium rates and with a higher annual benefit maximum ($200,000 instead of $75,000). The Board and the plans share annually in the cost of the aggregate losses about premiums. The Board pays for the State's share of subsidy from the same $40 million annual appropriation that funds MRMIP. The new rules took effect September 1, 2003.

Lesley Cummings was appointed Executive Director of the Board in July. At that time, she was the Chief Deputy Director and had previously served as Deputy Director of Administration and Fiscal Integrity. A month later, Clifford Allenby, who had been reappointed to the Board in 2001, was again appointed Board Chair. Governor Davis also appointed Virginia Gottlieb, M.P.H to the Board.

The Board was now large enough to go solo and end its long relationship for administrative support with the Office of Statewide Health Planning and Development. The Board established its own Personnel, Business Services and Budget Units and worked out a transition plan with OSHPD, through June 2003. The Board continued to go outside for accounting services, which were provided by the Contracted Fiscal Services Unit at the Department of General Services.

2003:

Governor Davis' final appointment to the Board was Richard Figueroa, who had previously served the Board as Deputy Director for Eligibility and Marketing.

The state budget crisis continued to affect the Board and its programs. Fortunately, there were no cuts in program enrollment for either AIM or HFP, but funding for outreach and paid application assistance fees were pulled from both programs. The Board lost eleven staff positions.

For HFP, the Board applied a "stone soup" approach to outreach and application assistance. It took over part of the School Health Connections outreach project from DHS and renamed it Connecting Kids to Healthcare through Schools. The project, in collaboration with the Public Health Institute and funded by the David and Lucille Packard Foundation, provides training and outreach materials to schools, with the tie–in that improving access to health care would improve school attendance and performance.

It took over part of the School Health Connections outreach project from DHS and renamed it Connecting Kids to Healthcare through Schools.

The Board also kept training application assistants in community based agencies, even though there were no longer any paid application assistance fees or outreach grants. With these efforts, coverage grew to 683,305 children by the end of the year.

The other major event was the re-procurement of the Administrative Vendor Contract for HFP, the Single Point of Entry (SPE) and AIM. Board and DHS staffs were involved in evaluating the proposals. Two proposals were received and in April 2003, the Board awarded the contract to MAXIMUS, Inc. After an eight month transition period, MAXIMUS took over the administrative vendor role for HFP and SPE from EDS on January 1, 2004.

The Guaranteed Issue Pilot Program in MRMIP was implemented in September 2003. By the end of 2003, 9,594 persons were terminated from MRMIP pursuant to this pilot. Of these, 7,832 initially select a guaranteed issue product under the pilot project.

The Health Trailer Bill to the 2003-04 Budget Act included a major change to the AIM (Chapter 230, Statutes of 2003; AB 1762). Under the change, AIM infants born to mothers who enrolled in AIM on or after July 1, 2004 would be automatically enrolled into the HFP and receive at least one year of coverage in HFP. This change allowed the state to get SCHIP matching funds for all infants born to AIM mothers. AIM enrolled 7,559 new mothers in 2003.

In October, Governor Davis signed Chapter 673, Statutes of 2003 (SB 2). This Act, a "pay or play" law, would have provided health coverage either through the employer or through the state-run insurance pool, starting in 2006 to employees in firms with 200 or more employees, and starting in 2007, for employees in firms with 50 or more employees. Employers who did not offer coverage at a defined benefit level would be required to pay into a state fund, to be administered by the Employment Development Department. The Board would use these funds to establish the State Health Insurance Purchasing Pool to provide coverage. The Act was strongly opposed by portions of the business community. A referendum on the November 2004 ballot, Proposition 72, required voter ratification of SB 2. In November 2004, the voters narrowly rejected SB 2 by a less than one per cent margin.

2004:

Automatic enrollment of AIM infants into HFP began.

The Federal Government approved the State Plan Amendment for entry of four counties into the C-CHIP, but required that the Board contract directly with county government rather than the Local Initiative Plans or County Organized Health Systems.

After another six month transition, MAXIMUS took over administration of the AIM Program from Care 1st Health Plan in July. At the same time, automatic enrollment of AIM infants into HFP began. AIM enrolled 8,256 new mothers in 2004.

The state budget crisis remained, but the 2004-05 Budget continued funding for enrollment growth in HFP and AIM. However, the Budget Act froze the capitation rates paid to HFP plans at the 2003-04 levels.

The Board began the first re-procurement of health, dental and vision plan contracts since 2000. All but one of the existing contractors renewed their participation and the Board added one returning health plan, one new dental plan and two new vision plans. New contracts would begin in July 2005.

By year end, HFP had an enrollment of 697,305 children.

As an initial result of the Guaranteed Issue Pilot Program, the MRMIP waiting list was eliminated for the first long term time since the start of the program and the enrollment projections were raised for combined enrollment in both MRMIP and the Pilot Program. However, only 6,199 people remained enrolled in Guaranteed Issue Pilot Project coverage.

2005:

To take full advantage of available SCHIP matching funds, the 2005-06 Budget Act provided for use of federal funding for the cost of mothers in the AIM Program and to cover the pregnancies of undocumented women in Medi-Cal, which the Federal Government had allowed since 2002. State law was enacted specifying that the recipient of services was the pregnant woman (Chapter 23, Statutes of 2005; AB 794). The Federal Government approved the State Plan Amendment in March 2006.

As part of the Omnibus Health Trailer Bill accompanying the 2005-06 Budget Act, the Legislature established the County Buy-In Program at the Board (Chapter 80, Statutes of 2005; AB 131). Under the concept, counties who do not have the resources to manage a county health insurance program for children ineligible for HFP or Medi-Cal could access the Administrative Vendor services of MAXIMUS and the established network of health, dental and vision plans, put in place by the Board for the HFP. This program is currently in the early stages of implementation.

As part of the Omnibus Health Trailer Bill accompanying the 2005-06 Budget Act, the Legislature established the County Buy-In Program at the Board (Chapter 80, Statutes of 2005; AB 131).

The state budget crisis eased somewhat and the 2005-06 Budget restored funding for application assistance fee payments in HFP. Many of the lost staff positions at the Board were also re-established.

2006:

The Governor's budget proposes to re-establish an outreach and media campaign for enrollment of children into HFP and Medi-Cal. It further provides for simplification of the HFP application process by eliminating the requirement that families submit a premium payment with the application and by making an electronic application process (Health-e-App) developed for HFP and Medi-Cal directly available to program applicants. Health-e-App is a joint project of DHS, the Board, and was funded by grants from the California Health Care Foundation. Previously, Health-e-App had been limited to certified application assistants at authorized Enrollment Entity sites and county welfare departments.

The Board issued a Fact Book on MRMIP and the Guaranteed Issue Pilot which is due to expire in September 2007. The Board also adopted principles for legislation calling for a high risk pool that is not subject to enrollment caps.

The Board moves into its sixteenth year of providing services to California's hard to insure populations.

The Board moves into its sixteenth year of providing services to California's hard to insure populations and providing advice and insight to state and national decision makers on health access policy. The Board moves forward with the knowledge that it has had the respect and confidence of four gubernatorial administrations, the Legislature, the Federal Government, its partners in the health insurance industry and the nearly one million clients served.